Medicare modernization: the new prescription drug benefit and redesigned Part B and Part C

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The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 was enacted in November 2003 and became effective on January 1, 2006. Two major changes occurred. A prescription drug benefit is now available for seniors and younger persons with disabilities who are covered by Medicare. The managed care program, formerly known as Medicare + Choice, has been redesigned and renamed Medicare Advantage.

MEDICARE 101

When Medicare was created in 1965, its purpose was to protect seniors from the catastrophic costs of long hospital stays and expensive medical procedures (1–3). Since then, Medicare has expanded the scope of its benefits, the populations it covers, and, consequently, its costs.

In 1970, 20.1 million Americans were covered. Today, there are 41.7 million beneficiaries. Consequently, federal spending for Medicare services has grown from $7.5 billion in 1970 to $308.9 billion in 2004. Due to demographic trends, Medicare enrollment will continue to grow at an increasing rate over the next 30 years. By 2030, Medicare estimates that there will be over 78 million beneficiaries. There is growing concern that the revenues coming into the federal government to fund Medicare will be insufficient to cover the growing costs of the program. The baby boom generation, expected to reach the age of 65 beginning in 2010, brings additional urgency to these concerns.

Most Medicare spending is for hospital services, followed by physician services and then managed care. Because prescription drug coverage has been limited in the traditional program, spending for this category comprises a small fraction of total spending. This will significantly change now that the prescription drug benefit has been implemented.

The Centers for Medicare and Medicaid Services (CMS) administers all aspects of the Medicare program, including making decisions about covered services, determining payment rates and policies, administering claims, educating beneficiaries and health care providers, and conducting research on alternative health care delivery systems.

There are four distinct parts to the Medicare program: Parts A, B, C, and D. CMS organizes, funds, and administers each part separately.

Part A

Part A insures acute inpatient hospital and post–acute care services. Prescription drugs used in these settings have been and will continue to be covered. Funding is provided through payroll taxes and beneficiary cost sharing. There is no monthly premium, and this part of Medicare insurance is offered "free of charge" to most US citizens who have been employed for 10 years. However, beneficiaries who use Part A covered services (inpatient hospital, skilled nursing facilities) must share the cost through an annual deductible and daily copayments.

Part B

Part B, also known as supplementary medical insurance, includes services such as physician and nonphysician services, hospital outpatient and ambulatory surgical centers, durable medical equipment, prosthetics and orthotics, clinical laboratory services, pharmaceuticals used in conjunction with a physician service, certain oral products (immunosuppressive agents, oral oncolytics, vaccines), certain preventive screenings, and ambulance services. Funding for Part B is provided from general tax revenues and beneficiary monthly premiums. Copayments from the beneficiary are required at the time of service and are usually 20% of allowed charges.

Part C

Part C, formerly Medicare + Choice, has been renamed Medicare Advantage. Part C was developed to provide Medicare beneficiaries an option other than the traditional fee-for-service program. Medicare Advantage is the managed care plan for beneficiaries. It is administered through the private sector, which receives a "per member per month" payment for each beneficiary it enrolls. The managed care organizations must provide at least the full range of benefits of Part A and Part B. In theory, managed care should offer benefits above and beyond the traditional fee-for-service program, thereby gaining favor with the Medicare population. However, only 11% of beneficiaries

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(46.6 million) have chosen this option, and enrollment steadily declines as the years progress.

Part D

Part D, the new outpatient prescription drug benefit, began paying for drugs through private plans in January 2006 (4). Private-sector entities vying for this business include managed care organizations and prescription drug–only plans. These entities have contracted with pharmaceutical manufacturers for their respective drugs. Once they decided on their formularies, the managed care organizations or prescription drug–only plans submitted a bid to CMS for the cost of providing this benefit. To be eligible for Part D, individuals must be enrolled in Part A or Part B.

PART D: THE STANDARD DRUG BENEFIT DESIGN (4)

Every managed care organization or prescription drug plan offering Part D must adhere to certain minimum standards (4):

- CMS has tentatively set the monthly premium at $37 per month (or $448 annually).
- The beneficiary has an annual deductible of $250.
- For drug costs between $251 and $2250, Medicare and the plan will share 75% of the cost and the beneficiary will pay for the remaining 25%.
- For drug costs between $2251 and $5100, the beneficiary is responsible for 100% of the cost; this is referred to as the gap or doughnut hole.
- For drug costs exceeding $5100, Medicare will pay 80%, the plan will pay 15%, and the beneficiary will pay 5%.

Based on the above guidelines, annual out-of-pocket costs for a Part D beneficiary will be, as of today's date, $3600 ($250 annual deductible, 25% coinsurance) to reach the catastrophic threshold. It is important to note that the annual premium, drugs not included in the plan's formulary, employer wrap-around benefits, and manufacturer's patient assistance programs are not included in calculating out-of-pocket costs. Deviations from the standard drug benefit can occur only if the offer is better than the standard or can provide "actuarial equivalence."

Types of plans

Part D can be administered through two types of plans. A Medicare Advantage Prescription Drug Plan (MA-PD) is a Medicare Advantage plan that also offers the drug benefit. Under contract with CMS, a stand-alone prescription drug plan (PDP) may be chosen by beneficiaries enrolled in the fee-for-service program.

The MA-PDs and PDPs receive funding through monthly premium subsidies from the government that are risk adjusted to reflect variation in drug costs among beneficiaries, monthly premiums, prescription copayments, reinsurance payments for high-cost beneficiaries, and risk-sharing payments from the government if a plan's total drug cost is unexpectedly high in a given year.

Plans available in Texas

In Collin, Dallas, and Tarrant counties, Humana and Secure Horizons offer MA-PDs (5). Depending on the plan chosen, beneficiaries can expect a monthly premium, including the drug premium, ranging from $0 to $64. All of the drug premiums in these plans are less than the $37 per month set by CMS. The drug deductible ranges from $0 to the $250 set by CMS in the standard drug benefit.

Twenty organizations in Texas offer 47 different stand-alone PDPs (5). Depending on the plan chosen, monthly premiums range from $10.31 to $68.41. The drug deductible ranges from $0 to the $250 set by CMS in the standard drug benefit.

Choosing a plan

Beneficiaries must choose a plan by May 15, 2006. The Medicare Spotlights home page (http://www.medicare.gov) provides information to assist beneficiaries in choosing a plan. This website includes a landscape of local plans, which lists all prescription drug plans by state; a plan finder, which compares the benefits of different plans; and a formulary finder, which lists plans that offer beneficiaries' required drugs.

Formularies and other cost-containment tools

The US Pharmacopeia was charged with developing model therapeutic categories and classes that MA-PDs or PDPs may use as part of their drug benefit formularies. These guidelines are necessary to protect Medicare beneficiaries' access to the drugs they need and to support the government's efforts to implement the drug benefit. Plans choosing to adopt the Model Guidelines are provided "safe harbor"; they are given protection from scrutiny of their therapeutic classification system by the CMS.

The Model Guidelines, released on January 3, 2005, consist of 41 broad therapeutic categories based on similar groups of diagnosis codes; 137 pharmacologic classes generally based on similar mechanisms of action or chemical structure; and 146 unique therapeutic categories and pharmacologic classes. A plan's formulary must include at least two drugs in each therapeutic category or class. CMS may require more than two drugs per class when additional drugs offer unique and important efficacy and safety advantages.

As currently employed in the managed care setting, plans can use standard cost-containment tools including drug formularies, tiered copayments, generic drug substitutions, therapeutic substitutions, restricted pharmacy networks, prior authorization, and step therapy.

Dual eligibles

Dual eligibles are beneficiaries who qualify for both Medicare and Medicaid. There are over 6 million dual-eligible individuals. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires that these individuals receive their prescription drug coverage through Medicare, not their state's Medicaid program. A small copayment for each prescription is required; however, nursing home residents are exempt from the copayment.

Low-income subsidies

The federal government subsidizes beneficiaries who cannot otherwise afford the prescription drug benefit under Part D. The Part D cost sharing and benefits for low-income beneficiaries are as follows:

- Up to 100% of the federal poverty level: no premium, no annual deductible, $1 to $3 per prescription copayment, and no coverage gap
- Up to 135% of the federal poverty level: no premium, no annual deductible, $2 to $5 per prescription copayment, and no coverage gap
- Up to 150% of the federal poverty level: sliding-scale premium, $50 annual deductible, 15% per prescription copayment, and no coverage gap

CHANGES TO PART B

Dramatic changes to reimbursement also occurred for pharmaceuticals covered under Part B (4). In 2004, Medicare's reimbursement for most drugs was approximately 85% of the drug's average wholesale price. In 2005, Medicare's reimbursement was based on each drug's average sales price (ASP). CMS calculates ASP using sales data submitted by manufacturers. Multisource drugs were reimbursed at 106% of the drug's ASP. However, ASP is calculated using sales data for all drug products, both branded and generic, available in the market for that drug. Thus, the ASP for branded products that have generic competition is very low. The reimbursement rate for single-source drugs is the lower of 106% of ASP or wholesale acquisition cost.

In 2006, providers may choose the "106% of ASP" policy described above or participate in a new "competitive acquisition program" (CAP) (6). Physicians will have to choose whether to purchase drugs themselves and receive the 106% of ASP as reimbursement or purchase drugs from third-party vendors who have contracted with Medicare on a competitive basis. In the latter case, reimbursement is based on the contracted price. Implementation of the interim final rule has been delayed in an effort to further refine the program. Therefore, CAP will become available in mid 2006. The initial physician election period will begin in spring 2006.

CHANGES TO PART C

As mentioned earlier, Medicare + Choice has been redesigned and renamed Medicare Advantage in an effort to increase enrollment (4, 7). The major changes include enhanced payments to the plans and a regional preferred provider organization option. The MMA provides an increase in government payment to the Medicare Advantage sponsors in an effort to reduce cost sharing, enhance benefits, or improve provider networks. Additionally, regional preferred provider organizations will afford more options for beneficiaries in rural areas. Prescription drug coverage may also be included if the beneficiary selects that option.

All plans are required to competitively bid at the local and regional levels for the Medicare Advantage business. The competitive bidding system is intended to encourage plans to compete to offer the best benefits at the lowest prices for beneficiaries.

CONCLUSION

The MMA represents the most sweeping government reform in health care since the inception of Medicare in 1965. It promises to revolutionize many aspects of health care delivery as we know it today. This primer serves as a brief summary. Many details have been omitted and are still unknown. For more information, see the Centers for Medicare and Medicaid Services' website, http://www.cms.hhs.gov/medicarereform.

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